The Delivery of End-of-Life Spiritual Care to Muslim Patients by Non-Muslim Providers

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Islam is the world’s second largest religion after Christianity, and the third most practiced religion in the United States (Pew Research Center, 2017). According to the Pew Research Center (2015), there are an estimated 1.8 billion Muslims worldwide with approximately 3.45 million Muslims of all ages living in the United States. Muslims account for about 1.1% of the current U.S. population. The Pew Research Center indicates this number is expected to grow, and Islam could become the second most-practiced religion in the United States by 2030.

Spiritual care is an important aspect of holistic care but may be neglected by providers (Hellman, Williams, & Hurley, 2015). A significant barrier to spiritual care delivery stems from the lack of a shared definition of spirituality between providers and patients, contributing to awkwardness and confusion about what spirituality includes (Ramezani, Ahmadi, Mohammadi, & Kazemnejad, 2014). This problem is particularly relevant for Western providers attempting to deliver spiritual care to patients from diverse cultural backgrounds, such as Muslims (Markey, Tilki, & Taylor, 2017; Murcia & Lopez, 2016).

Providers should attempt to understand Islamic perspectives for health behaviors, treatment decision-making, and palliative care (Mataoui & Kennedy Sheldon, 2016). Knowledge of the perceptions of health and illness grounded in an individual’s cultural and religious beliefs, values, and practices is essential for cultural competence. Nurses from non-Muslim backgrounds may benefit from a greater understanding of Islamic values and cultural practices that may influence health beliefs, use of health care, and the impact of family dynamics and decision-making processes for patients (Rasool, 2015). This understanding is particularly relevant for providers delivering care during a serious or life-threatening illness when spiritual reflection accelerates.

Islamic spirituality is viewed as the presence of a relationship with Allah that affects the individual’s self-worth, sense of meaning, and connectedness with others and nature (Bonab, Miner, & Proctor, 2013). Spiritual care, recognized as an integral component of comprehensive palliative and end-of-life care, has been difficult to define (Marzband, Hosseini, & Hamzehgardeshi, 2016). Because most U.S.-based research defines spirituality according to Christian principles, there is a lack of information regarding Islamic spirituality. Furthermore, research shows many healthcare providers implement their own spiritual beliefs if they are uncertain about their patient’s preferences, which may result in the imposition of Christian beliefs on Muslim patients (McCormick & Min, 2014). To address the lack of knowledge about spiritual needs of Muslims facing a serious illness, authors conducted an in-depth review of existing literature to determine which aspects of Islamic spirituality were discussed more frequently. Identified articles served as the basis for determining essential aspects of Islam that providers need to understand as they deliver spiritual care to Muslims.

Methods

Literature Search Strategy

The search was limited to primary studies published in English 2005-2017. Because of the lack of more recent research and the limit-
ed availability of more recent studies, the search was expanded to include 12 years of data. PubMed, MEDLINE, Cochrane Library, SocIndex, and PsychInfo were searched using the key words terminal illness, hospice, spirituality, Muslim, and Islam. Key words were searched individually and in combination. Abstracts were reviewed for 82 articles, but 69 of these were excluded because they were not directly relevant to research of interest. Thirteen articles thus met criteria for analysis and were retrieved.

Data Extraction and Management

Relevant data pertaining to Islamic spirituality were extracted from the research articles and organized within a review matrix. Extracted data included information about authors and years of publication as primary identifiers, region and discipline, sample, purpose, and definitions or descriptions of spirituality.

Data Analysis

The matrix allowed important aspects of Islamic spirituality to be compared within and between studies for analysis. Each author completed independent line-by-line coding of the extracted data for important key words or descriptors. Once independent coding was completed, the authors met to discuss their codes and collapse similar codes into a common key word. Agreement on coding was reached by consensus.

The authors acknowledged the small number of retrieved articles and considered the need to expand the search to include older articles. However, because data saturation was achieved with the 13 articles, they decided not to expand the search.

Results

Sample Characteristics

The 13 articles were extracted from journals originating in nursing and other disciplines. Authors were from six countries, including Iran (n=6), Jordan (n=1), United States (n=2), Pakistan (n=1), Israel (n=1), Australia (n=1), and Malaysia (n=1). Because so few articles were found to focus on Islamic spirituality, one concept analyses also was included in the review. Synthesis of the articles uncovered three major categories that describe the essence of Islamic spirituality within the context of serious illness: Connection to Allah, Daily Practice, and View of Catastrophic Illness. These categories captured several requirements and tenets of Muslim beliefs healthcare providers may encounter and offered assistance for delivering care. Analysis suggested a hierarchical relationship between the attributes in which Connectedness to Allah is the supreme objective. In Islamic faith, Daily Practice and View of Catastrophic Illness directly affect Muslim perceptions of connectedness to Allah, who is viewed as being supreme above all else.

Connectedness to Allah

The individual’s relationship with Allah is the core of Islamic spirituality (Ahmad, Muhammad, & Abdullah, 2011; Bonab et al., 2013). Because the need for devout Muslims to connect with Allah is central to the Muslim faith, the focus of every action is to please Allah and follow His will. Muslims worship Allah directly with prayers and indirectly by obeying His will at all times (Ahmad & Khan, 2016; Rahnama, Khoshknab, Maddah, & Ahmadi, 2012). Every action should be determined within the context of connecting with Allah (Heydari, Khorashadizadeh, Heshmati, Mazloom, & Ebrahimi, 2016). The goal of a Muslim life thus is to strive continually to be closer to Allah, which in turn enables a better connection to the self, others, and nature (Bonab et al., 2013). The ability for spiritual health to foster a greater capacity for love makes it an important goal for people facing serious illness that could result in the end of their lives. Ahmad and co-authors (2011) outlined several activities in which Muslims engage for spiritual development and closeness to Allah. First, Islam (surrender) describes the rituals a Muslim will perform in an attempt to surrender to Allah. Surrender includes the acceptance of Allah’s will no matter how serious the consequences and acknowledges His supreme authority for knowing what is best. Iman (faith) is the point in which a Muslim is able to believe Allah is real despite the inability to experience Him with human senses or in a tangible way. Ahmad and colleagues explained it as, “the paradox of worshipping Allah as if Allah has become visible” (p. 38). Finally, Ihsan (virtue) is the pinnacle of the connection to Allah often experienced as an intense
awareness and complete connection. Achieving this level of faith increases a person’s ability to see Allah everywhere and at all times (Heydari et al., 2016).

**Daily Practice**

Muslims remain connected to Allah by participating in specific daily practices (Ahmad et al., 2011). Everything a Muslim does contributes to the overarching goal of worshiping and pleasing Allah according to His will (Cheraghi, Payne, & Salsali, 2005). Therefore, all aspects of Muslim life are guided by faith and ritual, which eliminates any distinction between spirituality and religion (Ahmad et al., 2011; Bonab et al., 2013). This is contrary to Western spirituality, in which spirituality and religion are viewed as interchangeable (McCormick & Min, 2014). Recognizing the intensity and pervasiveness of spiritual beliefs within a Muslim’s life and their relationship to religious rituals illustrate how important these beliefs and rituals are to spiritual health (Ahmad et al., 2011; Khan, Watson, & Chen, 2016). Several common daily practices are relevant to hospitalizations and thus should be recognized by providers as extremely important to Muslim spiritual health. Some practices might not be obvious to Christian providers because they do not mirror common Christian obligations.

**Prayer.** According to the five pillars of Islam, Muslims are required to pray five times per day: dawn, mid-day, midafternoon, sunset, and nighttime. To do this with reverence, they should face toward Mecca, a holy city in Saudi Arabia and the birthplace of the Islamic prophet Mohammad (Ezenkwele & Roodsari, 2013). As with Christians, prayer provides the sense of a direct connection to Allah and is considered a sacred time for Islam. Except in the case of an emergency, providers should avoid interrupting Muslim patients during prayer. Posting notes on a patient’s closed door could minimize disruptions, as would creating a schedule with the patient to anticipate the beginning and duration of sacred time.

Before each prayer, Muslims must perform the ablution (Wudu), which is the washing of exposed areas of the body (e.g., face, hands, feet). The provider can assist by assuring water and towels are available (Mataoui & Kennedy Sheldon, 2016). Patients unable to stand for prayers may sit on a chair or bed. If family or friends are not present, the provider may help to position debilitated patients for prayer (Ezenkwele & Roodsari, 2013).

**Cleanliness.** The ritual for cleanliness extends beyond ablution before prayer. The clothes and body of a Muslim patient must be kept clean at all times. Any soiling from urine, stool, vomit, or blood must be cleansed as soon as possible, especially before prayer. Being soiled will render the patient ritually unclean and unable to pray (Al-Shahri & Al-Khenaizan, 2005).

**Dietary practice.** Muslim patients do not eat pork or pork products, such as gelatin or fat (lard), and do not consume alcohol or alcohol-based products. Raw meat must be soaked in water to drain the blood before cooking. Muslims are permitted to eat only well-done cooked meat with no trace of blood found after cooking. They eat halal, which means the meat from animals is slaughtered according to Islamic traditions (Mataoui & Kennedy Sheldon, 2016).

**Modesty.** Ideally, Muslim patients should have a healthcare provider of the same gender. However, patients can be cared for by professionals from the opposite gender if necessary. Male healthcare providers caring for a female patient always should be joined by a female staff member or adult relatives of the patient. Exposure of any part of the patient's body should be limited to what is absolutely necessary and done gently with permission from the patient beforehand. Needless to say, even greater care should be taken when exposing private areas (Al-Shahri & Al-Khenaizan, 2005; Baddarni, 2010; Mebrouk, 2008; Padela & del Pozo, 2011; Salman & Zoucha, 2010).

**View of Catastrophic Illness**

Muslim patients understand that illness and suffering are a necessary part of life and the journey to meet Allah (Al-Shahri & Al-Khenaizan, 2005; Lovering, 2012; Rassool, 2015; Wehbe-Alamah, 2008). Muslims believe in divine predestination and attribute the occurrence of pleasure and suffering to the will of Allah (Al-Shahri & Al-Khenaizan, 2005; Baddarni, 2010). The Muslim patient creates the meaning of disease by reflecting on his or her connectedness with Allah, the self, and others (Heydari et al., 2016; Nabolsi & Carson, 2011; Schultz, Baddarni, & Bar-Sela, 2012). Muslims believe illness or wellness is Allah’s will, and humans must accept illness and death with patience and prayers. However, some Muslims may also wonder if illness is a punishment for sin, which may create an emotional struggle providers may witness (Alaloul, Schreiber, Al Nusairat, & Andrykowski, 2016; Harandy et al., 2010).

**Discussion**

According to Islamic text, spiritual care is a series of activities that aim to promote spiritual health and prevent spiritual distress (Marzband et al., 2016). This review identified several important beliefs and practices of Islamic spirituality to serve as a guide for non-Muslim providers. Three categories of Islamic spirituality were identified: Connectedness to Allah, Daily Practice, and View of Catastrophic Illness. These categories constitute the most essential elements of Muslim faith in context with health and illness. This may be an oversimplification of the complex and sacred beliefs of Islam but it was offered to promote an understanding of Islamic beliefs to assist non-Muslim nurses caring for Muslim patients in meeting their spiritual needs during hospitalization.

This work supports and is supported by previously published research such as reported by Abudari, Hazeim, and Ginete (2016), who conducted qualitative interviews with 10 non-Muslim
nurses working in Saudi Arabia to understand their experiences of caring for Muslim patients. Findings that closely aligned with the current article included the criticality of religious practice to patients’ well-being. See Table 1 for practical tips to help nurses understand the needs and preferences of Muslim patients and assist with translating these findings to practice.

A limitation of this review is the simplification of the complex structure of Islam into three identified needs. Authors recognize Islam has many more tenets and practices, but they hope this discussion will give providers a foundation on which to begin planning spiritual care for Muslim patients. Authors further recognize there are many sects of Islam and acknowledge the best way to know precisely what the patient needs is to ask him or her directly. The information provided in this article is not intended to replace open dialogue about spiritual needs between providers and patients, but to offer providers enough understanding to anticipate patients’ needs. These needs should be refined through direct, open dialogue between patients and providers.

**Conclusion**

Caring for culturally diverse patients is a mainstay of U.S. health care. Open and comfortable communication about spirituality between providers and patients is just as important for the Muslim population as for others. Spiritual communication can be complicated, however, when spiritual beliefs widely differ. Providing a basic understanding of Islamic spirituality promotes cultural competence and improves spiritual communication between patients and providers (Ahmad & Khan, 2016). [3]

**REFERENCES**

Abudari, G., Hazeim, H., & Ginete, G. (2016). Caring for terminally ill Muslim patients: Lived experiences of non-Muslim nurses. *Palliative & Supportive Care, 14*(6), 599-611. doi:10.1017/S1478951516000249


**TABLE 1. Practical Tips for Muslim Spiritual Care**

<table>
<thead>
<tr>
<th>Visiting the Sick</th>
<th>Muslims may have many visitors (relatives, neighbors, and friends) who are required to visit the sick as an obligation of charity.</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>A Muslim patient may welcome support of visitors.</td>
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<tr>
<td>Support for Prayer</td>
<td>Support prayer by assisting patient to face Mecca.</td>
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<td></td>
<td>Support patient and family by ensuring the Qur’an and prayer mat are available in patient’s room.</td>
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<tr>
<td>Gender Considerations</td>
<td>Same-gender care is preferred to ensure female modesty.</td>
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<td></td>
<td>Unnecessary touching between non-related people of the opposite sex should be avoided.</td>
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<td></td>
<td>Respect a patient’s privacy by knocking before entering his or her room; announce your arrival and refrain from touching during conversation with the patient.</td>
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<td></td>
<td>Allow a close family member to assist patient with washing as preferred.</td>
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<td></td>
<td>Protect women patients in any potential interaction with men, ensuring patient’s genitalia are covered at all times.</td>
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<tr>
<td>End-of-Life Care</td>
<td>Once initiated, life-saving equipment cannot be stopped unless physicians are certain of inevitability of death.</td>
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<td></td>
<td>Islamic law permits withdrawal of futile, disproportionate treatment based on consent of immediate family members who act on professional advice of physician in charge of case.</td>
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TABLE 1. Practical Tips for Muslim Spiritual Care
The Delivery of End-of-Life Spiritual Care to Muslim Patients by Non-Muslim Providers

Deadline for Submission: October 31, 2020

MSN J1813

To Obtain CNE Contact Hours

1. For those wishing to obtain CNE contact hours, you must read the article and complete the evaluation through the AMSN Online Library. Complete your evaluation online and print your CNE certificate immediately, or later. Simply go to www.amsn.org/library
2. Evaluations must be completed online by October 31, 2020. Upon completion of the evaluation, a certificate for 1.3 contact hour(s) may be printed.

Learning Outcome

After completing this learning activity, the learner will be able to discuss basic attributes of Islamic spirituality to assist in the delivery of end-of-life spiritual support to Muslim patients.

Learning Engagement Activity

• Nurses and health care team members provide care at end of life with respect for spiritual beliefs and practices. Identify the three categories of Islamic spirituality (see Figure 1) and how they impact providing respectful care to Muslim patients at end of life.

• Review Table 1. Practical Tips for Muslim Spiritual Care to gain a basic understanding for managing end-of-life care for the Muslim patient.

Fees — AMSN Member: FREE  Regular: $20

Padela, A., & del Pozo, P.R. (2011). Muslim patients and cross-gender interactions in medicine: An Islamic bioethical perspective. Journal of Medical Ethics, 37, 40-44. doi:10.1136/jme.2010.037614